Supreme Court, U.S.
FILED
APR 9 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

On Writ of Certiorari
to the Supreme Judicial Court for
the Commonwealth of Massachusetts

REPLY BRIEF FOR THE PETITIONER

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April 1986

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REPLY BRIEF FOR THE PETITIONER

In our main brief, we demonstrated that the Secretary by regulation, which was adopted at the inception of the Medicaid program in 1966 pursuant to an express delegation of authority in the final clause of 42 U.S.C. § 1396a(a)(17), has consistently authorized states to use

a spenddown period of up to six months, and that the great majority of states which have chosen to extend their Medicaid coverage to include the optional medically needy program have done so on that basis. We further demonstrated that the language of the 1982 amendment inserting 42 U.S.C. § 1396a(a)(10)(C)(i)-(III), taken as a whole, could not literally be applied to the spenddown determination, and that the legislative history of the amendment clearly shows that it was not intended to override the Secretary's longstanding regulation (which the House Report expressly reaffirmed), but was directed instead to an entirely different purpose. We argued that the Secretary's interpretation pursuant to a broad grant of authority within an incredibly complicated statute, not having been plainly overridden by

Congress, was entitled to controlling weight. Respondents do not refute these essential points, but they do raise several arguments to which we respond briefly.[1/]

1. The First and Second Circuits were correct (despite Respondents' Brief, Point III) in holding that 42 U.S.C. § 1396a(a)(17) is the source of the Secretary's authority for the six-month spenddown regulation, 42 C.F.R. § 435.831. Hogan v. Heckler, 769 F.2d 886, 892 & n. 12, 902 (1st Cir. 1985), petition for cert. filed sub nom. Hogan v. Bowen, No. 85-6386; DeJesus v. Perales, 770 F.2d 316, 327 (2d Cir. 1985

1/ We refer to "respondents" in the plural because this is a properly certified class action, and the Brief for Respondent McKenna, whose status as class representative is undisputed, is perforce on behalf of the class.

petition for cert. filed, No. 85-6337.[2/]

The final clause of § 1396a(a)(17), which delineates the spenddown concept, specifically gives to the Secretary the authority to "prescribe" the "extent" to which participating states must take incurred medical costs into account in determining medically needy Medicaid eligibility. The six-month rule literally addresses one important aspect of the extent to which states have latitude in taking medical costs into account. It comes within the plain meaning of the express delegation of authority conferred in the statute.

2/ See also Brief for the United States as Amicus Curiae at 12-14; Medicaid Program; Deduction of Incurred Medical Expenses (Spend Down), Notice of Proposed Rule-Making, 48 Fed. Reg. 39960 (Sept. 2, 1983) (specifying § 1396a(a)(17) as the authority for proposed amended spenddown regulations).

Respondents gain nothing from their argument that the six-month rule originally was contained in, and derives its force from, a closely related regulation concerning the availability of income. Respondents' Brief at 26-27. The Secretary also has express legislative authority on that subject, contained in 42 U.S.C. § 1396a(a)(17)(B). The heightened deference to which that delegation of authority is entitled recently has been specifically reaffirmed by this Court. Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 43-44 (1981).

Since the Secretary's authorization of a six-month spenddown was made (and has been maintained for twenty years) pursuant to an express delegation of prescriptive authority, it is entitled

to great weight. Id. "These principles of deference have particular force in the context of this case." Aluminum Company of America v. Central Lincoln Peoples' Utility District, ___ U.S. ___, 104 S. Ct. 2472, 2480 (June 5, 1984). The statute under consideration is abstruse and complex; the Secretary "has longstanding expertise in the area, and was intimately involved in the drafting and consideration of the statute by Congress;"3/ and "[f]ollowing enactment of the statute, the agency immediately interpreted the statute in the manner now

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3/ As to the agency's intimate involvement, see Wilbur D. Mills, "Building a Better Safety Net," Health Care Financing Review (1985 Annual Supplement) at 1; Wilbur J. Cohen, "Reflections on the Enactment of Medicare and Medicaid," id. at 3-11.

under challenge." Id.[4/]

Respondents' interpretation of § 1396a(a)(10)(C)(i)(III) therefore cannot be correct unless that amendment has implicitly repealed the delegation of authority to the Secretary in § 1396a(a)(17). We demonstrate in ¶ 3, infra, that Congress has not done so. "It is, of course, a cardinal principle of statutory construction that repeals by implication are not favored." Parsons Steel, Inc. v. First Alabama Bank, ___ U.S. ___, 106 S. Ct. 768, 772 (1986).

2. The six-month spenddown regulation was not adopted (despite Respondents

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4/ The Secretary's interpretation thus represents "a contemporaneous construction of a statute by the men charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new." Id. (citations omitted).

Brief, Point II) under a delegation of authority in § 1396a(a)(10)(C) which has since been repealed. That delegation concerned an entirely different subject.

The provision in question originally read as follows:

> (B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan [of cash assistance] and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide-- . . .
>
> (i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care or services, and . . ..

42 U.S.C. § 1396a(a)(10)(B), as enacted

in 1965 by 79 Stat. 345, P.L. 89-97, § 121(a) (emphasis added).[5/]

The delegation of authority referred to by respondents, "as determined in accordance with standards prescribed by the Secretary," clearly modifies the determination as to which "one of such State plans . . . is appropriate," and does not relate to the verb "provide" or to the separate subparagraphs which follow.[6/]

5/ The text as amended in 1973 in respects immaterial here and renumbered as 42 U.S.C. § 1396a(a)(10)(C) by P.L. 93-233, § 13(a)(3), is reproduced in the appendix to Respondents' Brief.

6/ The phrasing of the delegation otherwise makes no sense. The key word in the delegation is "determined." It makes sense for the Secretary's authority to govern the determination as to which of the state plans is appropriate. It does not make sense to suggest that the "as determined" clause somehow modifies the verb "provide," or the objects thereof.

This common-sense reading of the statute is confirmed by the legislative history. The House Report described the original version of this section as follows:

> (B) if the plan under title XIX includes medical assistance for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide--
> . . .

H.R. Rep. No. 213, 89th Cong., 1st Sess. 184 (1965) (emphasis added). The Senate Report is practically identical:

> (B) if the plan under title XIX includes medical or remedial care and services for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide (except as to care and services described in section 1905 (a)(4) or 1905 (a)(14)) -- . . .

S. Rep. No. 404, 89th Cong., 1st Sess., Pt. I, reprinted in 1965 U.S. Code Cong. & Admin. News at 2145-46 (emphasis added).7/

Since this express delegation of authority concerned only the determination as to which state cash assistance plan was the appropriate reference point for

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7/ Respondents' argument also is premised upon a misinterpretation of the term "comparable standards." The "standards" referred to in subparagraph (i) were standards of need, i.e., income and resource levels; moreover, the comparability required was only among the various medically needy groups. See Schweiker v. Hogan, 457 U.S. 569, 573-74 n. 6 (1982); S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, 77, reprinted in 1965 U.S. Code, Cong. & Admin. News at 2017; H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965); R. Stevens & R. Stevens, Welfare Medicine in America: A Case Study of Medicaid (1974), at 63; Reply Brief for the Appellant at 6-7, Schweiker v. Hogan, No. 81-213 (U.S. (March 1982). This phrase did not extend, as respondents would have it, to the rules for making financial eligibility determinations, nor did it require comparability between the categorically and the medically needy.

particular groups of medically needy applicants, it is immaterial to this case (and also was not an expression of displeasure with the Secretary) that Congress in 1981 deleted both the underlying substantive provision (in the interest of according greater flexibility to states) and the associated delegation of authority along with it.[8/]

8/ The suggestion that the Secretary's six-month spenddown rule prior to 1981 was intended to "accommodate[ ] the then existing outside parameters of Medicaid eligibility," Respondents' Brief at 6, 18, has no basis. The Secretary's promulgation of the six-month rule was not done to accomodate the respondents' hypothetical three-month SSI budget period plus three-month retroactive Medicaid coverage. SSI was not enacted until six years later. Moreover, the Secretary provided that eligibility for the three-month retroactive period must be "separately determined; i.e., by applying a quarterly medically needy income level . . . ." Department of Health and Human Services, Medical Assistance Manual § 4.30.30(B)(1)(b)(1) at 13 (1976); see

(footnote continued)

This delegated authority had no connection to the six-month spenddown regulation, and its repeal has no bearing here.9/

(footnote continued)

also 48 Fed. Reg. 39959-61 (Sept. 2, 1983). Also, the original language of the rule encouraged a prospective budget period of "preferably no more than three months." Department of Health, Education and Welfare, Handbook of Public Assistance Administration §§ D-4220(A)(4), D-4230(4) (1966); see DeJesus, 770 F.2d at 323, n. 8. Finally, the Secretary has never applied the rule as an "outer limit." Under such an approach, the length of the budget period would have depended, not upon any determination by the state, but upon the characteristics of each applicant. Such a variable period clearly does not comport either with the intent of the Secretary's regulations or with the practice of the States prior to OBRA.

9/ Moreover, respondents' suggestion that Congress was motivated to withdraw the delegation by HHS' misinterpretation of OBRA cannot be correct, since the withdrawal was part of OBRA itself. The dynamics of the interaction between Congress and the Secretary in 1981 and 1982 prove simply that when Congress disapproves of the Secretary's financial eligibility regulations, it is not hesitant

(footnote continued)

3. The definition of income is not the issue in this case (despite Respondents' Brief, Point I), nor is it especially important to the proper resolution of the issue. The issue is whether a six-month spenddown under § 1396a(a)-(17) is prohibited by the "same methodology" requirement of § 1396a(a)(10)-(C)(i)(III). The proper resolution of this issue requires consideration of the language of § 1396a(a)(10)(C)(i)(III) in its entirety. Respondents fail even to address the plain fact that the mandatory

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(footnote continued)

to take corrective action. When Congress took such action in 1982, it expressly endorsed the six-month spenddown regulation, see H.R. Rep. No. 757, Part I, 97th Cong., 2d Sess. 13 (1982), which was adopted pursuant to authority conferred in § 1396a(a)(17) which has never been withdrawn.

datory language of that provision -- "which shall be the same methodology which would be employed under the appropriate State plan" -- literally cannot be applied to encompass the spenddown determination. See Brief for the Petitioner at 32-34.

"First, always, is the question whether Congress has directly spoken to the precise question at issue." Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S. Ct. 2778, 2781 (1984). Congress has not done so in § 1396a(a)(10)(C)(i)(III), or at least not favorably to the respondents. The terms "methodology" and "income eligibility" are not defined in Title XIX, nor are their scope and application to the spenddown plainly addressed by § 1396a(a)(10)(C)(i)(III). It is not

§ 1396a(a)(10)(C)(i)(III), but the final clause of § 1396a(a)(17), that is specifically addressed to the determination of how persons having incomes higher than the medically needy income standard -- i.e., who are ineligible because of their income -- may still qualify for Medicaid on the basis of the cost of their medical care.10/

10/ In determining whether § 1396a(a)(10)(C)(i)(III) encompasses and trammels the spenddown determination of § 1396a(a)(17), the two provisions must be read together. Herweg v. Ray, 455 U.S. 263, 276-77 (1982); Fullington v. Shea, 320 F. Supp. 500, 504-05 (D. Colo. 1970), aff'd summarily, 404 U.S. 963 (1971); Duparquet Co. v. Evans, 297 U.S. 216, 218 (1936). Indeed, § 1396a(a)(17), as the section specifically dealing with the medically needy spenddown, is of greater force. See Clifford F. MacEvoy Co. v. United States, 322 U.S. 102, 107 (1944); Hogan v. Heckler, 769 F.2d at 902. See also p. 7, supra.

Whereas § 1396a(a)(10)(C)(i)(III) is directed to areas of the eligibility determination common to the categorical cash programs and to Medicaid, the spenddown of medical costs for medically needy eligibility is entirely foreign to AFDC or SSI. It is directed to the fundamental difference that the categorically needy lack income to meet their basic needs for maintenance as determined in the context of the cash welfare programs, while the medically needy have income in excess of such needs -- and yet may qualify for Medicaid due to the cost of medical care which they require. As Judge Friendly explained:

> In Medicaid lingo, the spend-down is not part of the "standard to be employed in determining income and resource eligibility." That standard, so far as concerns income, is whether an applicant's monthly income after deduction of various expenses (other than medical expenses) and disregards

> is not more than the Medicaid income level set by the state. The spend-down is not part of this standard; rather, it is the method by which a family that does not meet the standard can nonetheless bring its excess income down to the level required for inclusion in the Medicaid program.

DeJesus v. Perales, 770 F.2d at 326.[11]/

The respondents urge, however, that the spenddown is "simply another deduction" from income, and on this basis is subject to the "same methodology" requirement. Respondents' Brief at 8, 26. This view of the spenddown fundamentally

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11/ Contary to Respondents' Brief at 12-13, DeJesus did not conclude that a "literal reading" of § 1396a(a)(10)-(C)(i)(III) would include the length of the spenddown period. The "literal reading" excerpt is from a general, introductory comment, 770 F.2d at 321. When addressing the merits of the case the court stated, with respect to the precise question here: "This is a problem as to which the Act seems to be silent." Id. at 327.

distorts its special role and particular purpose in determining an applicant's need for medical assistance not just in terms of whether his income is sufficient to meet his basic maintenance needs, but by reference to the cost of necessary medical care as well. See, e.g., S. Rep. No. 404, supra at 79, 1965 U.S. Code Cong. and Admin. News at 2019.[12/]

12/ Section 1396a(a)(17) itself distinguishes between disregards from income, which are treated in § 1396a(a)(17)(B), and the spenddown determination, which is specified in the final clause of the section. The spenddown concept was highlighted within Congress in 1965 as one of the most important aspects of the Medicaid program. See S. Rep. No. 404, Part 1, 89th Cong., 1st Sess., 10, 78-79, reprinted in 1965 U.S. Code, Cong. & Admin. News 1943 at 1951, 2018-19, H.R. Rep. No. 213, 89th Cong., 1st Sess. 10, 68 (1965) (which also describes this determination in annual terms). It has always been an extra step, considered only when an applicant has income in excess of the income standard. See, e.g.,

(footnote continued)

Quite apart from its erroneous premise, respondents' proposition cannot be squared with the plain meaning of the statutory language, particularly the word "same" and the entire phrase, "which would be employed under the appropriate State plan." See Brief for the Petitioner at 32-34. If by "income eligibility" Congress meant to include the determination of net income in the sense of eligibility after incurred medical expenses are taken into account, then § 1396a(a)(10)(C)(i)(III) is internally inconsistent. The methodologies for

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(footnote continued)

42 C.F.R. § 435.831 (1985); 42 C.F.R. § 448.1(a)(2)(ii) (1977); Department of Health & Human Services, Medical Assistance Manual § 4-30-30(B)(1)(d) at 16 (1976); Mass. G.L. c. 118E, § 10.

counting, excluding, deducting and disregarding items in the calculation of net income under AFDC and SSI do not permit the deduction of incurred medical costs. The state cannot use the same methodologies which would be employed under the AFDC plan or in SSI and include a spenddown within the compass of the requirement at the same time.

Respondents argue, in effect, that this Court should ignore the fact that the spenddown is completely different from AFDC and SSI and focus only upon its length. If the statutory language -- which encompasses what types of income and deductions to include, see Brief for the United States as Amicus Curiae at 20; Brief for the Petitioner at 31-32 -- includes any part of the spenddown, it includes those irreconcilable areas of

difference; but it does not clearly and unambiguously extend to budget periods (let alone spenddown periods).[13] A budget period applies at least as much to the determination of the income standard to be applied[14] as it does to the

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13/ Massachusetts by regulation measures income for the medically needy, for determining eligibility against the income standard, in monthly terms. 106 C.M.R. §§ 505.320, 506.410. It also specifies a six-month budget period, id. § 505.300, which appears to be of little practical significance except at the spenddown stage (as to which, see id. § 506.510). In Hogan v. Heckler, supra, 769 F.2d at 888-89, the First Circuit concluded that the state effectively applied a one-month budget period to those medically needy applicants who qualified without a spenddown. There was no evidence on this subject in Hogan, and none below in this case. In any event, as the First Circuit recognized, there would be no inconsistency between using different periods for the determination of income eligibility and of the spenddown liability.

14/ The income standard officially is an annual amount, see 42 U.S.C. § 1396b(f), and is so reported in the state plan.

determination of net countable income and, to the extent applicable, the spenddown of excess income through incurred medical costs.[15/] In any event, conforming the spenddown period to the budget period of the categorical programs would not remove the conflict inherent in trying to reconcile "same methodology" with any spenddown determination at all.

Respondents ultimately take the position that "same" does not mean what it says, asserting somewhat cryptically that

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15/ See Morris v. Morrow, 783 F.2d 454, 462 (4th Cir. 1986) ("A methodology provides an amount which must then be adjusted by the budget period employed by the state and which is then applied against a standard for that budget period to determine eligibility."); Camacho v. Perales, No. 85-7139 (2d Cir. 1986) (slip op. at 7150) (questions of "how long" relate to standards not methodologies). Despite Respondents' Brief at 26, Camacho does not hold that the spenddown is a methodology for determining income eligibility, see slip op. at 7149-50.

"same" -- the most likely candidate in the statute for a "plain meaning" -- should instead be interpreted to mean "at least" the same. Respondents' Brief at 7, 22.[16/] Amici supporting respondents also argue that "same" does not mean what it says. Brief for Susan Reed et al.[17/] But this approach, of

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16/ The legislative history which they cite in support of this proposition, however, does not contain any such qualifier. See H.R. Conf. Rep. No. 97-208, 97th Cong. 1st Sess. 971, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, at 1333. In addition, it is clear from the legislative history of TEFRA that the reference to "eligibility criteria" in Conf. Rep. 97-208 meant only substantive, not financial, eligibility criteria. See H.R. Rep. No. 757, Part I, 97th Cong., 2d Sess. 13 (1982).

17/ There is nothing in the language or legislative history of § 1396a(a)(10)-(C)(i)(III), however, which supports the "no more restrictive" gloss which they advance. Also, they misread 42 C.F.R. § 435.401(c), which governs substantive,

(footnote continued)

course, requires going beyond the "plain meaning" on the face of the statute. And if "same" is not a clear statement

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(footnote continued)

not financial, eligibility. This regulation stems from the original requirement that medically needy coverage extend to "all individuals who would, if needy, be eligible" for cash assistance, 79 Stat. 345, 42 U.S.C. § 1396a(a)(10)(B)(i) (quoted at p. 8, above) (subsequently amended in immaterial respects and moved to § 1396a(a)(10)(C)(i) by P.L. 93-233, § 13(a)(3); later deleted by OBRA, § 2171(a)(3)). It originally was prefaced: "Except for need . . .," 45 C.F.R. § 248.10(c)(3) (1971). This later became: "Except for financial eligibility . . .," see, e.g., 42 C.F.R. § 448.2(b) (1977). The present language was the result of a reorganization of the Medicaid regulations in which "[n]o policy changes have been made." 43 Fed. Reg. 45176 (Sept. 29, 1978). Its "no more restrictive" slant derives simply from the fact that Title XIX permits eligibility on a broader substantive basis than the underlying categorical programs. See 42 U.S.C. § 1396a(a)(10)(A)(ii). Of course, the petitioner disputes any suggestion that the spenddown is "more restrictive," no matter what its length, in the first place.

of congressional intent, it certainly cannot be concluded that the much more indefinite language "methodology for determining income eligibility" has a scope in relation to the length of a spenddown period which has been directly, clearly and unambiguously addressed by Congress.18/

The context of the enactment of § 1396a(a)(10)(C)(i)(III) and the legislative history are set forth at length in the Brief for the Petitioner. Respondents do not dispute that since the inception of Medicaid HHS has permitted states to use a budget period and a

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18/ The petitioner's position is that "same" should be interpreted in accordance with the legislative history of § 1396a(a)(10)(C)(i)(III) to mean "pre-OBRA." See H.R. Rep. No. 97-757, Pt. I, 97th Cong., 2d Sess. 13 (1982). But see Camacho v. Perales, supra, No. 85-7139 (2d Cir. 1986) (slip op. at 7142-47) ("same" means what it says; rejecting a "no more restrictive" gloss).

spenddown of up to six months, pursuant to which most states choosing to have a medically needy program used a six-month period; and that to require a one-month spenddown would have represented a very significant change to the program, imposing a substantial economic burden upon at least 23 states and the District of Columbia or requiring a significant reallocation of resources by those jurisdictions. There is no suggestion in the legislative history of any congressional intent to require any such change; nor does the legislative history contain any criticism of the Secretary's six-month rule. Instead, the legislative history is clear that Congress enacted § 1396a(a)(10)(C)(i)(III) only to correct HHS' misunderstanding of § 2171(a)(3) of OBRA, and intended to reinstate the prior

regulatory scheme, a scheme in which six-month spenddowns abounded (side-by-side with monthly AFDC and quarterly SSI eligibility determinations). See DeJesus, 770 F.2d at 327; Hogan v. Heckler, 769 F.2d at 901. The House Committee Report, H.R. Rep. No. 97-757, Pt. I, 97th Cong., 2d Sess. 13 (1982), graphically pinpoints this limited purpose, and expressly endorses the six-month spenddown regulation; it is an "authoritative source" of Congressional intent. Garcia v. United States, ___ U.S. ___, 105 S. Ct. 479, 483 (1984).

4. Respondents (and amici supporting them) more generally misapprehend the context which bears upon the congressional intent in enacting the "same methodology" requirement.

In enacting Medicaid in 1965, Congress treated the categorically needy more favorably than the medically needy; and it did so because the former are the most needy group. Schweiker v. Hogan, 457 U.S. 569, 572-73 (1982); see also id. at 578-80 (similar intent in the 1967 amendments). The six-month spenddown is consistent with this approach because, in the context of voluntarily expanding the state's Medicaid program beyond the categorically needy, it allocates the state's resources to the most needy of potentially eligible applicants. While we certainly do not deny that those who narrowly fail to qualify under the six-month spenddown are nonetheless needy,[19/] it also can hardly be denied

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19/ Despite the hyperbole of the Brief Amici Curiae of Gray Panthers Advocacy

(footnote continued)

that those who are targeted by the six-month spenddown, whose medical bills exceed their excess income over a six-month period, are generally in greater need.20/

The imposition of a one-month spend-

(footnote continued)

Committee, et al., the point in the Brief for the Petitioner at 67 n. 41 was simply that the six-month period was consistent with a congressional concern expressed in the 1967 debates. By the same token, the Gray Panthers' description of hardships, in this complex and difficult area of social policy, is properly addressed to Congress -- or to the Massachusetts legislature. In those states with no medically needy program, the individuals they describe -- and many in greater need -- are automatically ineligible.

20/ As the Brief for the United States as Amicus Curiae at 18 illustrates, any effort to draw lines among the needy is difficult and subject to criticism, including a one-month spenddown which involves inequities of its own.

down, while benefitting some medically needy applicants or recipients, would doubtless require a reallocation of resources through, e.g., the state's contracting its range of covered services, lowering its medically needy income standard or restricting its coverage to less than all medically needy groups -- all areas, like the length of the spenddown period, in which Congress has given flexibility to the States. Such adjustments would adversely affect those who presently qualify for Medicaid.21/

21/ See Brief for the United States as Amicus Curiae, at 16-18. The state continues to explore ways of reducing hardship from the credit problems of those with regularly recurring medical expenses in excess of their monthly excess income. See Hogan v. Heckler, 769 F.2d at 891, n. 10. Raising the income standard appears to be one effective means to this end. See Mass. St. 1985, c. 140 (item 4402-5000) (providing that the Medicaid

(footnote continued)

In enacting OBRA §§ 2315(a) and 2341(a) (requiring monthly budgeting and retrospective accounting in AFDC and SSI, respectively), Congress was motivated only by considerations of accuracy and cost-saving within AFDC and SSI.[22] There is no merit to respondents' suggestions (Respondents' Brief at 6-7, 19-23)

(footnote continued)

standard for a single individual be set, at state expense, above the limit of 42 U.S.C. § 1396b(f), to match the income level for an individual SSI recipient (plus the optional state supplement), thus increasing the need standard from $383 to $440 per month, and decreasing the spenddown over a six-month period by $342).

22/ Respondents argue that monthly budget periods for AFDC were not required prior to OBRA. We submit they are incorrect; but our point, which respondents do not appear to deny, was that this was the universal practice. See DeJesus, 770 F.2d at 323, n. 9; S. Rep. No. 97-139, 97th Cong., 1st Sess. 440, reprinted in 1981 U.S. Code, Cong. & Admin. News 396, at 706.

that the congressional criticism of HHS' implementation of OBRA § 2171(a)(3) extended to HHS' "failure" to incorporate OBRA §§ 2315(a) and 2341(a) into the Medicaid context. The plain fact is that Congress' criticisms were focused specifically upon HHS' response to § 2171(a)(3), and have never extended to the implementation of these other sections or to the continued existence of the six-month spenddown regulation. See H.R. Rep. 757, Pt. I, 97th Cong. 2d Sess. 13 (1982); 127 Cong. Rec. 23358 (Oct. 6, 1981) (remarks of Rep. Waxman).[23/] The six-month spenddown is consistent

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23/ Contrary to Respondents' Brief at 23-24, HHS has made very clear in the public record its view that TEFRA did not affect the six-month spenddown authorization. See Medicaid Program; Deduction of Incurred Medical Expenses (Spend Down), Notice of Proposed Rule-Making, 48 Fed. Reg. 39959, 39960-61 (Sept. 2, 1983).

with the essential Congressional purpose underlying both OBRA and TEFRA, which emphasized cost-saving and granted flexibility to States to achieve it.24/

5. Respondents say (at 4, n. 7) that they do not rely upon their claim under the "comparable standards" clause of 42 U.S.C. § 1396a(a)(17); but that argument -- in the form of the theme that the statute has always contained a "no more restrictive" requirement -- in fact per-

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24/ Cf. Senator Dole's opening statement in the Senate debate on TEFRA: "In reducing spending, the Finance Committee sought to improve administration of programs and focus assistance more precisely upon those who are most in need." 128 Cong. Rec. S8645 (daily ed., July 19, 1982) (middle column) (emphasis added).

vades their brief.[25/]

The § 1396a(a)(17) claim is properly before this Court. It was asserted in the Complaint and in the Intervenor's Complaint (J.A. 21, 44); it was exten-

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25/ This theme appears especially in the argument at Point IIA that the Secretary's six-month regulation prior to OBRA was an attempt to be consistent with such a mandate (but see n. 8, supra), and in the argument at IIC that Congress intended to retain a "no more restrictive" requirement when enacting OBRA (but see n. 16, supra). The theme is linked to § 1396a(a)(17) specifically in Respondents' Brief at 13, n. 11. Contrary to the assertions there, Schweiker v. Hogan, 457 U.S. 569, 587-88 (1982), specifically held that 42 U.S.C. § 1396b(f) was consistent with, and not an exception to, § 1396a(a)(17). Also, Beltran v. Myers, 451 U.S. 625 (1981), was not brought under the "comparable standards" provision of § 1396a(a)(17), as was respondents' claim in this case, but under a different provision, § 1396a (a)(17)(B). See 451 U.S. at 626, n 1. That case involved transfer-of-assets rules that violated the non-financial eligibility provision of § 1396a(a)(10)-(C)(i), and 42 C.F.R. § 435.401(c) promulgated thereunder. See n. 17, supra; Fabula v. Buck, 598 F.2d 869, 872-73 (4th Cir. 1979).

sively briefed by both parties in the trial court and the Supreme Judicial Court; it was encompassed within the question presented in the Petition for Certiorari; and the respondents in their Brief in Opposition indicated an intention to rely upon § 1396a(a)(17) in defense of the judgment. Moreover, the petitioners in DeJesus v. Perales, No. 85-6337, and in Hogan v. Bowen, No. 85-6386, both of whom are represented by counsel for the respondents here, asserted (in the respective Petitions for Certiorari, at i) that the issue was presented in this case in this Court.

If respondents have waived the claim we have no objection. But we do object to respondents' suggestion, if such it be, that the issue be preserved for remand. Such a result would extend, rather than resolve, uncertainty as to the

validity of the six-month spenddown. Moreover, once the Court decides that § 1396a(a)(17) delegates authority to the Secretary pursuant to which the six-month regulation was properly adopted, the respondents' argument based upon the initial clause of § 1396a(a)(17) necessarily falls. The fundamental differences between the categorically needy and the medically needy, which are embodied in the spenddown clause and are at the heart of why the "same methodology" requirement is not transgressed here, are equally applicable to a like resolution of the § 1396a(a)(17) claim. Resolution of the "same methodology" claim will require an understanding of § 1396a-(a)(17), so it simply makes sense to resolve both claims at the same time.

For the foregoing reasons and the

additional reasons set forth in the Brief for the Petitioner, the judgment of the Supreme Judicial Court should be reversed.

Respectfully submitted,

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April 1986